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| Trinity Logo | Trinity Surgery | Form checked by |
|  | 29 St Augustines Road |
|  | Wisbech, Cambs, PE13 3UZ |
|  | Tel: 01945 476999  www.trinity-surgery.co.uk |

**Children’s New Patient Registration Questionnaire aged 16 and Under**

When you returning your child’s new patient registration forms please make sure you bring with you:

* Birth certificate.
* Photographic identification
* Your child’s NHS number, you can obtain from your previous doctors surgery.
* If your child is taking regular medication please ensure you obtain 1 month’s medication from your previous surgery to allow us time to add the medication to their notes. You must also bring a copy of the repeat prescription with this form.
* Any vaccination records you may have.

PLEASE MAKE SURE THAT YOU HAVE FULLY COMPLETED THIS QUESTIONNAIRE BEFORE RETURNING IT TO THE RECEPTIONIST. THERE WILL BE A DELAY IN YOUR CHILDS REGISTRATION WITHOUT ALL THE REQURIED INFORMATION AND DOCUMENTAION.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title\* | | Date of birth:\* DD/MM/YYYY | | |
| First name\* | | Surname \* | | |
| Gender | Male \* | Female \* | | Other –*please specify* |
| Mothers name \* | | | | Parental responsibility |
| Fathers name \* | | | | Parental responsibility \* |
| Country of birth \* | | | | |
| Main language spoken of parent if an interpreter required. | | | | |
| Foster carer / guardian name/s | | | | |
| Brothers or sisters name/s | | | | |
| Address: \* | | | | |
| Post code:\* | | | | |
| Mobile telephone number: \* | | | Home telephone number: | |
| We will use your mobile number to send appointment reminders & information texts. Please tick here if you give your consent for this. \* | | | | |
| Email address: | |  | | |

**Childs health information**

**Are you a young carer?**

Does anyone living with you have a disability, poor mental health or drug and alcohol problems?’  Yes  No

  ‘If you have selected yes, then you may be a young carer’

If you would like to talk to someone about this then please tick this box Yes  No

Please tell us who you care for and your relationship to them?

Name: Relationship to you?

|  |  |
| --- | --- |
| **Has your child had any serious illnesses or operations?** | **YES**  **NO**  \*  (please tick) |
| If Yes, what was this and when? : | |
| Does your child have a disability or chronic condition? | **YES**  **NO**  \*  (please tick) |
| If yes please give more information. | |
| **Is your child on any regular medication?** | YES  NO  \*(please tick) |
| If yes, please tell us the name and dose*: (if you have a list from your previous GP please give us a copy)* | |
| **Is your child allergic to any medication?** | YES  NO  \*(please tick) |
| **Which school or nursery does your child attend? \*** | |
| When returning this form please bring your child’s vaccination records. It is important that your child’s immunisations are kept up to date. Vaccination records enclosed YES  NO  \* (please tick) | |

**Ease of access due to disability/impairment/sensory loss**

Please tick if your child has any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Sight impairment | Hearing impairment | Disability | Other\* |

Please select your preferred method of contact:

|  |  |  |  |
| --- | --- | --- | --- |
| Letter | E-mail | Telephone Call | SMS Message |
| Other\* - Please state: | | | |

|  |  |
| --- | --- |
| **Please indicate the Ethnic group to which you feel**  **White**   * British * Irish * Any white background   **Mixed**   * White and Black Caribbean * White and Black African * White and Asian * Any other mixed background * **Asian or Asian British** | **your child you belongs:\***   * Indian * Pakistani * Bangladeshi * Chinese * Any other Asian background * **Black or Black British** * Caribbean * African * Any other black background * Arab * Any other ethnic group |

**Sharing of information and your health record**

Information about your child’s health and care help the NHS to improve your child’s individual care, speed up diagnosis, and plan your local services and research new treatments.

\*Share out- Will you consent to share your medical record with any other health care provider involved in your child’s care Yes  No

\*Share in- Will you consent to Trinity Surgery viewing information in your child’s medical record recorded by other health care services? Yes  No

Summary Care Record – your emergency care summary

The NHS in England introduced the Summary Care Record to be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you to have enough information to treat you safely.

Your child’s Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if your child has an accident or becomes ill, healthcare staff treating you will have immediate access to important information about your child’s health.

As a patient you have a choice:

\*Yes I would like a Summary Care Record – You do not need to do anything and a summary care record will be created for you.

\*No I do not want a Summary Care Record – Please ask reception for a Summary Care Opt Out form, complete it and return to the surgery.

**Nominated pharmacy**

All prescriptions will be sent electronically to your nominated pharmacy. Please indicate your preference. This can be changed at any time.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Well pharmacy | Boots Horsefair | Boots Walsoken | Boots Dehavailind Road | Tesco | Asda | Fairbrothers | Other |
|  |  |  |  |  |  |  |  |

**Please retun this form with your childs birth certificate,**

**FOR OFFICE USE ONLY:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Birth certificate | Red book | Sharing | Regular medication. If yes do not accept without repeat prescription | | Vaccination records | Childs details completed | Nominated pharmacy | Registration letter given | Date |
|  |  |  | **Y ** | **N ** |  |  |  | **Y ** |  |